The information on the following pages will help make sure that your child is scheduled for appropriate evaluations according to their needs. Please complete this information to the best of your ability. You will be contacted once we have reviewed the information to schedule appointments.

Today’s Date:

**PERSONAL INFORMATION**

Child’s Legal Name:

Child’s Preferred Name, if different than Legal Name:

Child’s Date of Birth:

Child’s Gender:

Pronouns: he/him/his she/her/hers they/them/their other

How would you like us to describe your or your child’s race/ethnicity: (e.g., American Indian, Alaska Native, Asian, Black, African American, Hispanic, Latinx, Native Hawaiian, Other Pacific Islander, White)

Parent/Guardian Name(s):

Name & relationship of person completing this form, if different from Parent/Guardian(s):

Home Address:

Home Phone & Cell Phone Number:

E-mail Address:

Is your child in DCF care?

If so, please indicate DCF case worker’s name & contact information:

Please be aware that DHHP professionals are fluent in American Sign Language (ASL) and/or have access to the services of an ASL Interpreter. Do you or the child need an ASL Interpreter and/or a spoken foreign language interpreter in a DHHP appointment? If so, please indicate which language(s):

The following information is helpful for your healthcare providers as they prepare for the child’s appointment. Please answer the questions to the best of your ability.

**MEDICAL HISTORY**

Please describe the child’s hearing levels: (i.e., moderate-severe hearing loss; mild sensorineural hearing loss, etc.)

Does the child have any other medical needs? (i.e., Vision Loss, Autism

Spectrum Disorder, Cytomegalovirus, etc.) If so, please list them.

Where does the child receive Audiology care?

*If the child is seen outside of Boston Children’s Hospital, please include any audiology, otolaryngology (ENT), speech-language pathology, or behavioral/developmental records.*

***List your questions, issues, or concerns below and how DHHP may be able to help you.***

**BIRTH HISTORY**

Did you or your doctor(s) note problems with any of the following? If so, please describe

 Pregnancy:

 Labor:

 Birth:

The child being seen is the \_\_\_\_\_ of the mother’s pregnancies (i.e., first, second, third, etc.)

Was this child born full-term?

What was the mother’s age at the time of this child’s birth:

What was the father’s age at the time of this child’s birth:

If your child joined your family though adoption, please indicate the country where they were born:

What was the age of the child when they arrived home?

Are medical records available from the birth country?

**MEDICAL HISTORY**

Has anyone in the family experienced the following? If so, please describe:

 Mental Health Concerns (anxiety, depression, etc.)

 Intellectual Disability

 Neurologic Disease or Disorder

 Seizures/ Epilepsy

Has this child experienced any of the following? If so, please describe

 Jaundice

 Rh Problems

 Chemical Abnormalities

 Seizures

 If so, at what age?

 Were seizures associated with a high fever?

 Serious Illness

 Hospitalizations

 Surgeries

Does this child complain of abdominal pains/vomiting? YES NO

Does this child complain of headaches? YES NO

Does this child have vision problems? YES NO

Does this child have any medication allergies? YES NO

Does this child have any other allergies? YES NO

Is this child currently taking any medications? YES NO

**DEVELOPMENTAL HISTORY**

At what age did your child achieve the following milestones:

 First words (spoken or signed)

 Combining words (spoken or signed)

 Walking

 Fine Motor Skills (Fastening buttons, using zippers)

 Early School-related skills (Reciting the alphabet, Naming Colors)

 Sitting still for storytelling or television

 Playing and socializing with other children

 Building with blocks, playing with puzzles

At what age was the child toilet trained for daytime hours?
At what age was the child toilet trained for nighttime hours?

Has the child experienced any sleep problems? If so, please describe:

Does this child show a clear hand preference?

If left-handed, is anyone else in the family left-handed?

Does this child mostly play with younger, older, or same-aged children?

Does this child ever play with children of his or her same age?

Has this child ever received psychotherapy and/or counseling?

**FAMILY HISTORY**

Who lives in the household with the child? Please indicate their names & ages.

Please indicate parent/guardian(s) occupation?

What is the primary language in the home?

What is the primary language of the child?
Are any other family members D/deaf or hard of hearing?

Since the last DHHP appointment, have any significant changes occurred with the child’s needs?

Since the last DHHP appointment, have any significant changes occurred with the family?

**CHILD CARE**

Is the child in a daycare setting? If so, where?

Is the child cared for by a babysitter or nanny during the day?

**EARLY INTERVENTION AND SPECIALTY PROGRAMMING**

Does/did your family participate in Early Intervention (EI) Programming? If so, where?

At what age was your child enrolled?

What services does/did your child receive in EI?

Does/did your child participate in Specialty Service Programming for D/deaf and hard of hearing toddlers and families? If so, where?

At what age was your child enrolled in these services?

What services does/did you child receive in a Specialty Program?

**ACADEMIC HISTORY**

What is the name of the school or program that the child currently attends? Please include the town.

What grade is the child enrolled in?

Does the child receive any support in school? (i.e., speech-language therapy, occupational therapy, etc.)

Has the child received any school-related evaluations?

*Please attach any documents related to the child’s IEP, IFSP, or 504 Plan.*

***Who referred you to DHHP?***

***List any other information you feel is important for DHHP clinicians to know before evaluating the child:***

*Thank you for completing the Deaf and Hard of Hearing Program Intake. Did you know that our team coordinates Development and Training Workshops and Family Focused Outreach Events? Would you like to be added to our e-mail distribution list for future events? \_\_\_ YES \_\_\_ NO*

We will not, in any circumstances, share your personal information with other individuals or organizations without your permission.